



External Outcomes Evaluation Report

Children in Distress Network (CINDI)

May'khethele OVC Programme

Prepared by
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ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Treatment
ARV	Anti Retroviral
CINDI	Children in Distress Network
CCP	Community Care Project
DHA	Department of Home Affairs
DOH	Department of Health
DSD	Department of Social Development
HCT	HIV Counselling and Testing (an opt-out approach)
HIV	Human Immunodeficiency Virus
ID	Identity Document
LL	Lifeline
LO	Life Orientation
NAP	National Action Plan
NGO	Non-Governmental Organisation
PEPFAR	President's Emergency Plan For Aids Relief
OVC	Orphans and Vulnerable Children
STI	Sexually Transmitted Infections
VCT	Voluntary Counselling and Testing
YFC	Youth For Christ

Executive Summary

The May'khethele program was launched in October 2007 in the uMgungundlovu district of KwaZulu-Natal and aims to improve the lives of orphans and vulnerable children (OVC) through the provision of a comprehensive range of services. The programme operates at two levels. It provides school-based HIV education and HIV Counselling and Testing (HCT); and personalised, household level attention for OVCs who are identified and enrolled in the programme. The programme uses a consortium approach. Under the CINDI umbrella, it is implemented by four CINDI members: the Community Care Project (CCP), Lifeline, Youth for Christ (YFC) and, up until 2010, Sinani.

The evaluation is a retrospective outcomes evaluation of the May'khethele programme. It was guided by the following evaluation questions:

1. To what extent has the wellbeing of OVCs changed during their participation in the May'khethele programme?
2. To what extent did the school-based HIV prevention education programme improve attitudes and knowledge about HIV and AIDS, reduce stigma and influence change in sexual behaviours and HIV infection risk reduction among targeted adolescents? (Note that this includes all of the children who received the HIV prevention education programme).
3. How effective were the services provided to OVC households in terms of improving care to OVCs?
4. What management and institutional arrangements best support programme effectiveness? (This is an additional question emanating from the evaluation).

A mixed methods evaluation design was applied. This included primary document review, programme records analysis, a quantitative learner survey and qualitative focus groups and interviews. Qualitative results were analysed against the evaluation questions, using the PEPFAR programme areas as a thematic framework. Quantitative results were analysed using Chi-square and Fisher tests for significant differences.

Findings show that the wellbeing of OVCs enrolled in the programme has improved. Severely under-parented learners have been motivated to focus on their education, overcome substance abuse problems, and engage more positively in society. OVC have improved resilience and coping mechanisms, better access to HIV care and treatment, and have significantly better food security than their non-OVC counterparts in the same schools. The programme also assisted in improving child protection through removing OVC from unsafe living situations and finding homes for OVC living alone.

The school-based HIV prevention education programme is widely considered to have been highly successful, and an essential on-going element in school services. The availability of lay counselling by an approachable, knowledgeable, independent adult is a key success factor. There was increased knowledge among learners at intervention schools on transmission and prevention of HIV, improvement in learners' confidence and self-esteem and following their May'khethele experience, more learners are practicing safer sex or abstaining from sex. In terms of stigma, results were mixed with some schools experiencing a decrease, but stigma remaining a challenge in others. For HIV testing, uptake varied across the three May'khethele partners – which possibly indicates the need to strengthen the referral approach to testing used in the programme.

The comprehensive, integrated, child-centred, holistic, household level nature of OVC support has been effective and is recommended as good practice. The model demonstrates the value of the real needs of OVCs being addressed by a single caring adult and the value of support to physical needs being strongly complemented by support to emotional needs.

The consortium model employed by the May'khethele programme has been a highly successful approach. It enables both reach and depth in servicing OVCs; flexibility and adaptability; and capitalising on the strengths of each partner organisation providing for a range of skills and professional capacity. A key success of the model has been the commitment to strong project management and the establishment of crucial operating systems and processes. In addition to raising funds to roll out the model, the May'khethele programme intends to share this model with the sector as an example of best practice.

Overall the evaluation found that the programme is effectively designed to provide holistic education, care and support at school, home and community levels. This has provided several principles of good practice, having demonstrated how school-wide education, life-skills facilitation and counselling can be effectively integrated with needs-based household support. Recommendations include sharing the examples of good practice used by the programme as well as sharing the programme model with the OVC sector as part of May'khethele's sustainability plan.

1 THE MAY'KHETHELE PROGRAMME

1.1 THE CHILDREN IN DISTRESS NETWORK (CINDI)

The Children in Distress Network (CINDI) is a network of people and organisations that support children affected and infected by HIV and AIDS in the province of KwaZulu-Natal. The network consists of over 300 civil society and government organisations, including non-governmental organisations, community-based organisations, faith-based organisations and local and regional government departments¹.

1.2 THE MAY'KHETHELE ORPHANS AND VULNERABLE CHILDREN PROGRAMME

The May'khethеле programme was launched in October 2007 in the uMgungundlovu district of KwaZulu-Natal, and has been fully functional since January 2008. Services were provided to 5204 OVC in October 2007-September 2008; 11,722 in October 2008-September 2009; and 12,193 in October 2009-September 2010². May'khethеле expanded from 16 schools in 20 wards at the outset, to 57 schools in 29 wards by the end of 2011.

Aims and objectives

The May'khethеле programme aims to assist and support orphans and vulnerable children (OVC) through schools-based interventions³. The main objectives of the programme are:

- To increase life skills and improve the wellbeing of OVC under the age of 18 in 57 schools in uMgungundlovu district, through HIV/AIDS prevention education, promoting behaviour change, improving access to counselling and testing, and provision or linkage to other OVC services; and
- Identification of learners with particular vulnerability and providing them with responsive household level services, support and mentorship tailored to their needs, and addressing as far as possible the causes of their vulnerability.
- To increase knowledge and understanding of OVC care and support through provision of informal training to primary caregivers⁴.

Services

¹ www.cindi.org.za

² PACT, 2011

³ PACT, 2011

⁴ PACT, 2011

The programme aims to improve the lives of vulnerable children through the provision of a comprehensive range of services. The model includes:

- HIV prevention education for all learners in participating schools in grades 8-10, with an emphasis on holistic emotional well-being and personal development, integrated with sexuality and HIV education
- Psychological care through lay-counselling and referral for professional psychological support
- Voluntary counselling and testing for HIV
- Health care support and general healthcare referrals
- Educational support through provision of school uniforms and stationery packs for enrolled OVC
- Directly assisting OVC to access enabling documents and facilitating the provision of documents for all learners at participating schools
- Enabling and ensuring child protection, including removal from abusive situations
- Household Economic Strengthening, for OVC living in poverty, including facilitating access to social grants and establishment of household/community gardens.

The programme operates at two main levels:

School-based HIV education and HIV Counselling and Testing (HCT), and general counselling for all learners, including those enrolled as OVC in the programme. In the process, teachers develop skills and are exposed to rights-based learner support and HIV education, and schools develop systems which attempt to address vulnerability in their communities as a whole.

OVCs are identified and enrolled in the programme to receive **personalised, household level attention** through visits by a May'khethele carer. Their needs and those of their caregivers are assessed, and support or referral and follow-up services ensure that the child has greater access to rights.

Implementing partners

The May'khethele Orphans and Vulnerable Children's Programme is implemented by four CINDI members: the Community Care Project (CCP), Lifeline, Youth for Christ (YFC) and, up until 2010, Sinani. Participating schools are divided among the programme partners as lead agencies, each calling on the expertise and cooperation of the other members of the May'khethele team where needed (Table 1).

Partner	Primary services	Collaborative services
YFC	<ul style="list-style-type: none"> • Delivers HIV education at schools • Household based, personalised services to enrolled OVC at YFC schools 	<ul style="list-style-type: none"> • YFC refers OVC to Lifeline for facility based HCT
CCP	<ul style="list-style-type: none"> • Delivers HIV education at schools • Household based, personalised psychosocial and livelihood support services to enrolled OVC at CCP • Provides HCT in Schools, homes and communities (since 2010) 	<ul style="list-style-type: none"> • CCP refers learners to Lifeline for Rape Counselling HCT and professional counselling
Lifeline	<ul style="list-style-type: none"> • Provides HCT at schools, and includes sexuality and HIV education in individual counselling sessions • Provides professional psychological counselling where needed 	<ul style="list-style-type: none"> • Refers OVC to CCP and YFC for follow ups

Table 1. Service entry points and referral web among the three programme partners operating in secondary schools

2 BACKGROUND

The HIV and AIDS epidemic in South Africa has vastly increased the number of orphans and other vulnerable children (OVC) in need of care and protection. The United States President's Emergency Plan for AIDS Relief (PEPFAR), the funder of the May'khethele programme, defines OVC as follows:

"A child, 0-17 years old, who is either orphaned or made more vulnerable because of HIV/AIDS.

Orphan: has lost one or both parents to HIV/AIDs.

Vulnerable child: is more vulnerable because of any or all of the following factors that result from HIV/AIDS -

- *is HIV-positive;*
- *lives without adequate adult support (eg in a household with chronically ill parents, a household that has experienced a recent death from chronic illness, a household headed by a grandparent, and/or a household headed by a child);*
- *lives outside of family care (eg in residential care or on the streets); or*
- *is marginalised, stigmatised or discriminated against⁵."*

South Africa has one of the highest HIV prevalence rates, and the world's largest epidemic, with 5.7 million people living with HIV in the country in 2008⁶. Due to under-delivery of treatment to the necessary scale, around 400,000 AIDS deaths per year were recorded at a peak in HIV mortality rates⁷. Approximately 1.4 million children in South Africa had been orphaned by HIV/AIDS. Just over 1 out of every 4 children in the province of KwaZulu-Natal has lost one or both biological parents⁸, with the uMgungundlovu district affected by one of the highest HIV prevalence rates in the country. In addition, many children are HIV-positive themselves, through mother-to-child transmission of the virus.

2.1 THE IMPACT OF HIV ON OVC

Compared to other children, OVC are more likely to:

- have poor health and nutrition
- become HIV infected
- suffer sexual abuse, including child prostitution and trafficking
- lack emotional support to deal with grief and trauma
- experience long-term psychological problems

⁵ PEPFAR, 2006

⁶ Yezingane Network, 2010

⁷ Tremendous Hearts, 2010

⁸ Yezingane Network, 2010

- lack love, care and attention
- take drugs and other substances
- do badly in school and/or drop out of school
- have poor educational and vocational opportunities
- begin working early
- become involved in crime
- experience stigma and discrimination
- experience exploitation and abuse
- lose their rights to land and property⁹.

In an attempt to address the OVC crisis, the Department of Social Development (DSD) issued a National Action Plan (NAP) for OVCs in 2006. The current 2009 - 2012 NAP aims, inter alia, to strengthen family capacity; mobilise community-based responses for protection of OVC; ensure that legal and policy frameworks are enabling; and provide essential services for OVC¹⁰.

Aligned to the NAP's minimum package of services for OVCs, PEPFAR has identified a set of core programme areas¹¹:

- Clinical Nutritional Support
- Child Protection Interventions
- General Healthcare Referrals
- Healthcare Support for Access to Anti-Retroviral Treatment (ART)
- HIV Prevention Education
- Psychological Care
- Educational Support
- Household Economic Strengthening.

The May'khethale programme is closely aligned to the NAP objectives, and corresponds to the PEPFAR thematic programme areas to varying degrees.

⁹ International HIV/AIDS Alliance, 2003

¹⁰ Khulisa Management Services, 2008

¹¹ PEPFAR, 2012

3 EVALUATION PURPOSE AND GUIDING QUESTIONS

This report is structured according to the following evaluation questions:

1. To what extent has the wellbeing of OVCs changed during their participation in the May'khethele programme?
2. To what extent did the school-based HIV prevention education programme improve attitudes and knowledge about HIV and AIDS, reduce stigma and influence change in sexual behaviours and HIV infection risk reduction among targeted adolescents? (Note that this includes all of the children who received the HIV prevention education programme).
3. How effective were the services provided to OVC households in terms of improving care to OVCs?
4. What management and institutional arrangements best support programme effectiveness? (This is an additional question emanating from the evaluation).

The evaluation is a retrospective outcomes evaluation of the May'khethele programme using both quantitative and qualitative research methods. It is important to note that although the programme operated in primary and high schools this focus shifted towards high schools in the fourth year. As a result, primary schools were not included in this evaluation. In addition, one of the four partner organisations, Sinani, has left the programme and their work was not included in the evaluation.

4 METHODOLOGY

4.1 EVALUATION DESIGN

A mixed methods evaluation design was applied. This included primary document review, programme records analysis, a quantitative survey and qualitative focus groups and interviews. Respondents included OVC and other learners, teachers, programme facilitators and staff, NGOs and government stakeholders working in closely related fields.

Qualitative data sources included May'khethele staff interviews, OVC focus groups at schools, a Lifeline HIV support group for OVC who are HIV-positive, OVC caregiver interviews and focus groups, and key informant interviews.

Quantitative data were collected through a learner survey conducted in participating May'khethele schools (intervention schools) and control schools. The comparison with control schools was provided in an attempt to detect the relative outcomes of the programme at intervention schools.

4.2 SAMPLING STRATEGY

The sampling strategy for the learner survey used randomised, multi-stage sampling with probability proportionate to the size of beneficiary groups per school.

Ten intervention schools were selected randomly from the 35 participating high schools, with an even distribution of schools among the three partner organisations (Table 2). A total of 849 learners were randomly selected from 10 intervention schools and 4 control schools.

School	Number of learners		Intervention versus control		
	Count	Percentage	Classification		Percentage
Gobindlovu	81	9.5%	Intervention	YFC	64%
Edendale HS	77	9.1%			
Umthoqotho HS	66	7.8%			
Sukuma Comprehensive	69	8.1%	Intervention	CCP	
Zamazulu HS	68	8.0%			
Bongudunga	62	7.3%			
Georgetown	50	5.9%			
Skhululiwe SS	28	3.3%	Intervention	Life Line	
Imvunulo SS	24	2.8%			
Ikusaselihle HS	20	2.4%			

Willowfountain	92	10.8%	Control	36%
Bheximba HS	91	10.7%		
Mcomjwana HS	81	9.5%		
ML Sultan	40	4.7%		
Total	849	100%		

Table 2. Quantitative survey sample

Enrolled OVC (63% of the sample) and learners not enrolled in the OVC programme (37% of the sample) were selected in proportion with their numbers at the schools.

4.3 SAMPLE DEMOGRAPHICS

Although equal numbers of boys and girls were included from each stratified sample, more females (57%) than males (43%) were available to participate in the survey, for both control and intervention schools.

Learners from the control schools were older than those from the intervention schools, with 73% being aged 16 to 18, where only 48% of intervention school participants were in this age range. This is likely to have affected the results, particularly those related to sexual maturity.

Qualitative sample

A total of 181 participants made up the qualitative sample (Table 3):

Qualitative data source	Organisation / School	Number of participants	No. of females	No. of males
Staff interviews	Lifeline, CCP, YFC, CINDI	7	3	4
OVC focus groups	9 intervention schools	An average of 10 per group	46	43
HIV support group	Lifeline	12	10	2
3 x caregiver focus groups		42	41	1
5 x caregiver home visits		5	5	0
School key informant interviews	5 intervention schools	17	4	13
Key informant interviews	Dept of Health Dept of Home Affairs	9	5	4
Totals		181	114	67

Table 3. Qualitative sample

4.4 LIMITATIONS IN THE METHDOLOGY

4.4.1 Use of control schools

Although a few particularly dominant trends emerged, the comparison with control schools has been less effective than hoped. The quantitative results may be under-reporting positive outcomes of the programme. Where significant differences are detected between control and intervention schools, however, these would suggest a substantial level of outcomes, sufficient to overcome the sampling bias.

Three critical factors have contributed to the limited value of the intervention: control design:

- All schools in the area have had exposure to HIV education and OVC interventions.
- The age distribution of the learners in the control schools is not equivalent to the intervention schools.
- One of the control schools, ML Sultan, differed substantially from the intervention group. It is located in town, better resourced and has a high matric pass rate.

4.5 ANALYSIS

Qualitative results were analysed against the evaluation questions, using the PEPFAR programme areas as a thematic framework. Wherever appropriate the voices of respondents are provided in the text as an authentic representation of the perspectives that were communicated. Trends, examples and particular cases were identified, and the perspectives of informants used to explain, enrich and sometimes to contradict with quantitative findings.

Quantitative results were analysed using Chi-square and Fisher tests for significant differences. The survey responses from learners were analysed for comparison according to:

- Analysis for differences between intervention schools and control schools.
 - In order to attempt to dilute bias, the outlying control school, ML Sultan, was excluded from the analysis of sexuality and HIV education.
- Within intervention schools data, a further analysis was conducted on differences between respondents who were enrolled as OVC in the May'khethale programme and those who were not.

5 FINDINGS, ANALYSIS AND EMERGING RECOMMENDATIONS

5.1 EVALUATION QUESTION 1: CHANGE IN OVC WELLBEING

To what extent has the wellbeing of OVCs changed during their participation in the May'khethele programme?

Major conclusions

The wellbeing of OVCs enrolled in the programme has improved. Severely under-parented learners have been motivated to focus on their education, overcome substance abuse problems, and engage more positively in society.

Situations have been resolved where OVC are reported or found to live in abusive or unsafe home situations. OVC in need of medical treatment, and particularly learners living with HIV, have been referred and accompanied to ensure that treatment is provided. Several OVC have recovered from severe illness under the care of the programme. Nutritional needs have been met through referral and facilitation of welfare grants or food parcels, and through establishment of food gardens.

Although OVC were enthusiastic about the improvements in their confidence, self-esteem and emotional well-being, they continue to require regular personal support. Having been abandoned in some way in their past, programme continuity and trustworthiness is particularly critical if interference is not to have additional negative impacts in their lives.

5.1.1 Improved resilience and coping mechanisms

Many OVCs stressed that the counselling services are an important element of the programme, enabling them to cope better with problems and become more resilient. Counselling greatly assists OVC in coping with traumas such as the death of a parent/s or being HIV-positive themselves.

*"May'khethele has changed my life because I used to smoke dagga and drugs. Since I got involved with May'khethele and learnt the dangers of drugs, I have stopped. I'm more focused on my school work and go to church. I do my chores and homework. I have also distanced myself from bad friends and associate myself with friends that motivate me."*¹²

*"My life has changed a 100% with May'khethele. I used to do drugs because I was always stressed. May'khethele has shown that there are people I can talk to when I'm feeling down."*¹³

¹² OVC focus group 2

¹³ OVC focus group 2

Improved emotional well-being was especially visible among teenagers who participate in the programme's support group for learners living with HIV. The group had been facilitated through acceptance of their positive HIV status. They explained how the support group had restored their hope and has helped them cope with issues of anger, fear and isolation.

*"Before May'khethele I used to blame my mother for my status. I hated her, because amongst all my siblings, I'm the only one who is HIV positive. After joining the support group I made peace with myself. I forgave my mother."*¹⁴

*"When I found out that I was HIV positive, I got confused. I did not understand anything. I felt stupid and dirty. I was a bad girl. They made me become my old self and I realise that this is not my fault."*¹⁵

*"...I was angry because I was still a virgin. I even thought of sleeping around with everybody because I had saved myself and yet I got infected. They [May'Khethele] saved my life."*¹⁶

Many OVCs experience stigma and discrimination and they often feel isolated¹⁷. The programme helps OVCs feel more included in society.

*"When they first visited my home, my family was happy that there were people who cared enough about me to want to see where and how I lived."*¹⁸

The programme strategy of going into OVCs' homes shows these learners that their school life isn't separate from the community. They feel included, better connected and more valued¹⁹.

*"They [OVCs] feel they can be normal."*²⁰

5.1.2 Child protection and psychological support

Interviews and focus groups indicate that May'khethele is, to a certain extent, effective at identifying and removing OVCs from unsafe living situations. A children's welfare organisation noted that, *"Their support makes it easier to do our work - even though we may be working on a case, because they are in the community if they noticed a problem they will visit the child's home and check up for us"*²¹. People trust the programme enough to feel comfortable to report concerns they have about children²².

¹⁴ HIV positive support group focus group

¹⁵ HIV positive support group focus group

¹⁶ HIV positive support group focus group

¹⁷ PEPFAR, 2006

¹⁸ OVC focus group 2

¹⁹ Principal interview 4

²⁰ Teacher interview 2

²¹ NGO interview 3

²² NGO interview 3

The programme has also helped learners who do not have parents or who are living alone to find homes:

“I know one set of twins. They were staying at the orphanage. May’khethele organized foster parents for them.”²³

“There were four siblings going around asking for food, May’khethele took those learners to a foster home. They organised birth certificates for them and maybe IDs.”²⁴

Enrolled OVC, understandably, have more psychosocial challenges than their non-OVC peers. Significantly²⁵ fewer OVC felt “able to do things as well as most other people” and “as happy as other learners my age”, than non-OVC learners at intervention schools (Figure 1).

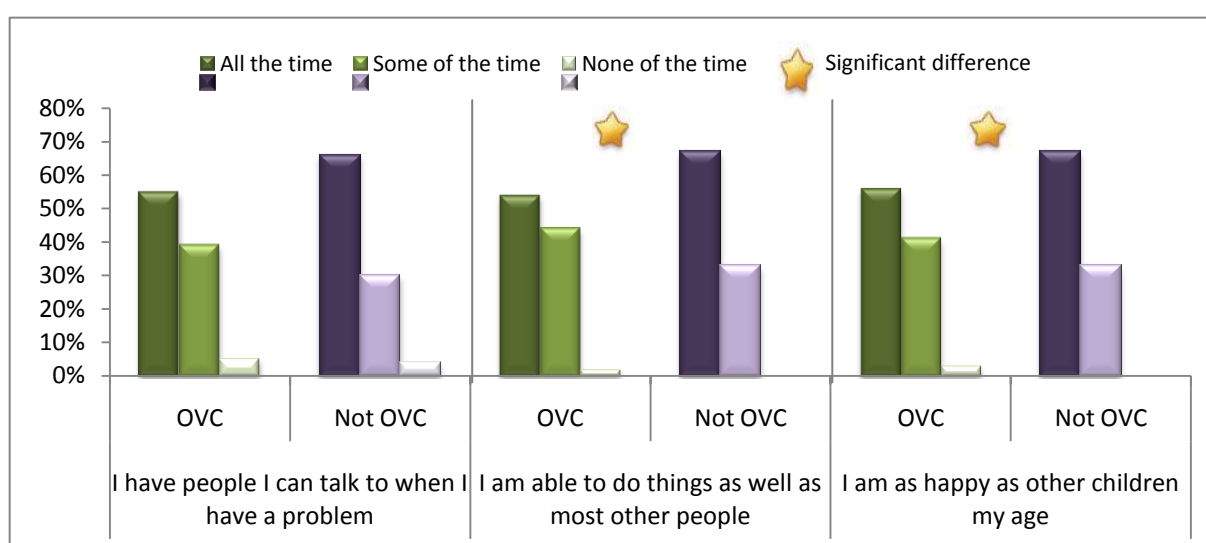


Figure 1. Comparison of OVC and non-OVC psychosocial support items

5.1.3 Improved access to HIV care and treatment

By enabling access to HIV testing the programme has identified adults and learners who are eligible for ART, who may otherwise have been missed. It has assisted them with accessing care and treatment, enabling the recovery of some of whom had reached Stage 4 AIDS.

“We have given learners another opportunity to live. Some learners’ CD4 count was 10. They didn’t know they had HIV and are 13 or 14 years old.”²⁶

“If it wasn’t for May’khethele my grandchild wouldn’t be alive today.”²⁷

²³ OVC focus group 4

²⁴ OVC focus group 4

²⁵ Chi-square = 8.665 p<0.05 and Chi-square = 6.688 p<0.05

²⁶ Staff interview 1

²⁷ Caregiver home visit 1

May'khethele facilitates immediate follow-up of positive HIV tests in consultation with the child and with his or her consent. A partner organisation conducts a CD4 count, enabling rapid access to treatment if necessary. May'khethele ensures continuity from testing, through treatment and care, to psychosocial support.

5.1.4 Differences in food security among enrolled OVC

Learners enrolled as OVC in the May'khethele programme have significantly better food security than non-OVC counterparts in the same schools: 31% always having 2 meals a day, compared to 20% of non-OVC learners. The majority of caregivers felt that the nutritional support provided by the programme was extremely valuable.

*“The most important thing to us is providing food and clothes for our children.
May'khethele really comes through for us.”²⁸*

5.2 EVALUATION QUESTION 2: THE HIV EDUCATION PROGRAMME

To what extent did the school-based HIV prevention education programme improve attitudes and knowledge about HIV and AIDS, reduce stigma and influence change in sexual behaviours and HIV infection risk reduction among targeted adolescents? Note that this includes all of the children who received the HIV prevention education programme.

Major conclusions

The school-based HIV prevention education programme is widely considered to have been highly successful, and an essential on-going element in school services. Programme beneficiaries recommended that May'khethele increase the amount of time it spends at schools and recommended that all grades in high schools be included in the programme, rather than only Grades 8 to 10.

The facilitation model provides an example of good practice, particularly with regard to building self-esteem, confidence, social responsibility and emotional maturity. A combination of personal upliftment with technical information has been particularly successful. Facilitation could be further enhanced with clear norms and standards for school facilitators.

A range of participatory teaching practices are used in the model, including dialogues, edutainment, and drama. Respondents noted the value of these practices and suggested including additional techniques such as learner debates on various salient topics and inviting more HIV positive champions to give talks to the learners.

²⁸ OVC caregiver focus group 2

The availability of lay counselling by an approachable, knowledgeable, independent adult is a key success factor, offering support, access to problem solving, and respect, thereby enhancing self-value and self-esteem. While professional psychologists are clearly essential in cases of severe trauma or abuse, readily available facilitators fulfill a valuable role for a greater number of learners.

Uptake of HIV testing varied considerably between the three May'khethele partners. HIV testing rates were highest at schools where the relevant partner organisation in the school provided testing directly. Testing rates were lower at schools where the partner organisation referred learners to another partner organisation or facility for testing. It is recommended that lessons learnt from the direct approach to testing are used to strengthen the referral approach.

Although condom distribution in schools is against DoE school policy, given the importance of condoms in HIV prevention, availability of condoms at convenient and youth-friendly collection sites is essential. Realistically, many learners are likely to be sexually active before they leave school at the age of 18. Access to condoms is facilitated by the May'khethele programme, although various social pressures around abstinence messaging, privacy and HIV may make it difficult for learners to request or obtain condoms openly. Carefully thought out strategies are needed which do not casualise sex among young learners, but which give young adults access to HIV prevention.

Although stigma has diluted substantially across schools in the sample, it is recommended that the programme continues to place emphasis on this topic. Deeper issues of stigma and fear of disclosure, and the need for peer support and supportive oversight for learners who become infected with HIV, all require continuous diligence around stigma and discrimination.

OVC have higher risk attitudes for certain HIV questions than non-OVC. This suggests that, while May'khethele has helped OVCs to develop safer and healthier attitudes to sexuality, these learners continue to be vulnerable and are the group that requires information and attention. Individual conversations on sexuality and HIV seemed to have been missed by the community outreach element of the programme. Home visits and frank, personal, relaxed conversation with a trusted, knowledgeable adult, remain a valuable resource for OVC. Continuing to discuss HIV and sexuality at home, being available to answer questions and, if appropriate, supplying condoms, is a valuable form of support.

School-based programmes are necessarily long-term, as generations of learners continue to need the same level and nature of educational and emotional support. Schools have gained enhanced capacity, but teachers feel that May'khethele fills a role that they themselves lack the time, skills or relationships with learners to fulfill.

5.2.1 School partnership

The presence of the programme in schools has enabled teachers to gain skills; HIV knowledge and understanding; access to Voluntary Counselling and Testing (VCT) for themselves and better relationships and communication with learners. Learners benefit from more supportive teachers and greater access to helpful adults. Schools now facilitate more parent participation and have increased outreach to their communities. May'khethele schools are gaining reputations for being schools of choice in their areas: *"More Grade 8s came to the school because of May'khethele. They heard what is going on here from their siblings."*²⁹

The majority of the schools stressed the importance of a good relationship between the school and the programme: *"we are working hand in hand with the programme."*³⁰ Principals and teachers agreed that it had taken some time to build a good relationship between the school and the programme but this had been achieved at most schools.

*"May'khethele has become part of the school's family."*³¹

Some respondents suggested that academic achievement has improved at their schools because of the programme. Others have noticed that learners are more focused in class and are learning better. A number of teachers attributed this improvement to the fact that May'khethele has mitigated many of the social, interpersonal and confidence issues which negatively affect learners' academic ability.

*"We had a 91% pass rate in 2011. This has never happened before. The learners are more serious about their school work because May'khethele has helped with their home situations."*³²

5.2.2 School-based facilitation

The May'khethele facilitators and counsellors at schools are young and engage with learners in a light and accessible manner. Learners relate to facilitators more openly than to their teachers, and do not regard them as authority figures. This enables a trusting relationship to develop and learners become comfortable discussing sensitive issues, disclosing abuse and requesting counselling.

*"They do not discriminate against the positives and they are able to keep your secrets."*³³

*"They do not shout at us, they talk to us like they are of our age."*³⁴

²⁹ Teacher group interview 4

³⁰ Principal interviews 1, 2, 4

³¹ Principal interview 2

³² Principal interview 5

³³ OVC focus group 1

³⁴ OVC focus group 1

*"The way they teach LO is different from how the teachers do it. They clarify things."*³⁵

*"They have great sense of humour you do not get bored with them."*³⁶

Teachers felt that it is easier for the facilitator to discuss sensitive topics such as sexuality and condom use. Facilitators also have more specialised knowledge and skills around social issues than many teachers, and are better equipped to share accurate information appropriately and effectively with learners³⁷.

Although the majority of school facilitators are effective and much appreciated, there have been problems with a few facilitators. For example, at one school a facilitator was replaced because the school felt that she was unable to relate to the learners and was straining the relationship between the school and the programme. May'khethele responded well and resolved the issue.

5.2.3 HIV prevention education in schools

Knowledge

CCP offers a school-based HIV prevention education programme for Grades 8 and 9, which takes place during Life Orientation class (LO) slots within the school timetable. YFC provides a similar programme for Grades 8-10. Lifeline offers HCT information sessions at schools. Focus groups and interviews all reported substantially increased knowledge among learners on transmission and prevention of HIV.

*"I'm teaching Life Orientation and you can see they [learners] have an understanding from May'khethele. They already know before you teach them."*³⁸

The survey confirms that learners at the intervention schools have significantly³⁹ more HIV knowledge than learners at the control schools (Figure 2). The higher scores from intervention schools on items such as "a person with HIV can look healthy", and that "sharing eating utensils does not carry a risk of HIV" illustrate significant positive shifts in learners' attitudes towards stigma, stereotypes and assumptions.

Learners now subscribe to fewer HIV myths, and teachers commented that learners can readily identify and explain typical HIV misconceptions. Learners are more aware of the consequences of unsafe sex and they understand the benefits of abstaining and using

³⁵ OVC focus group 4

³⁶ OVC focus group 1

³⁷ Teacher interview

³⁸ Teacher group interview 6

³⁹ Independent t-test with $t = 2.140$ and $p < 0.05$

condoms. Learners now have a detailed understanding of the different means of HIV transmission.

“The information we get from them [May’Khetele] helps us to know the importance of using a condom so as to prevent the chances of getting HIV.”⁴⁰

“We have learnt how to protect ourselves from STIs and HIV.”⁴¹

Of concern is that between 36% of the intervention group and 46% of the control group are under the impression that mosquitoes can transmit HIV. Although the intervention group are significantly better informed on this item, it is something that should be addressed, since it would drastically aggravate both anxiety and stigma.

An understanding of HIV as a chronic, treatable and manageable condition has been gained, and with it, important potential impacts on stigma and denial.

“If you are positive, you cannot become negative again. But if you listen to doctors, you can live for a long time”⁴²

“They teach you how you must behave if you are HIV positive.”⁴³

⁴⁰ OVC focus group 1

⁴¹ OVC focus group 3

⁴² OVC focus group 4

⁴³ OVC focus group 2

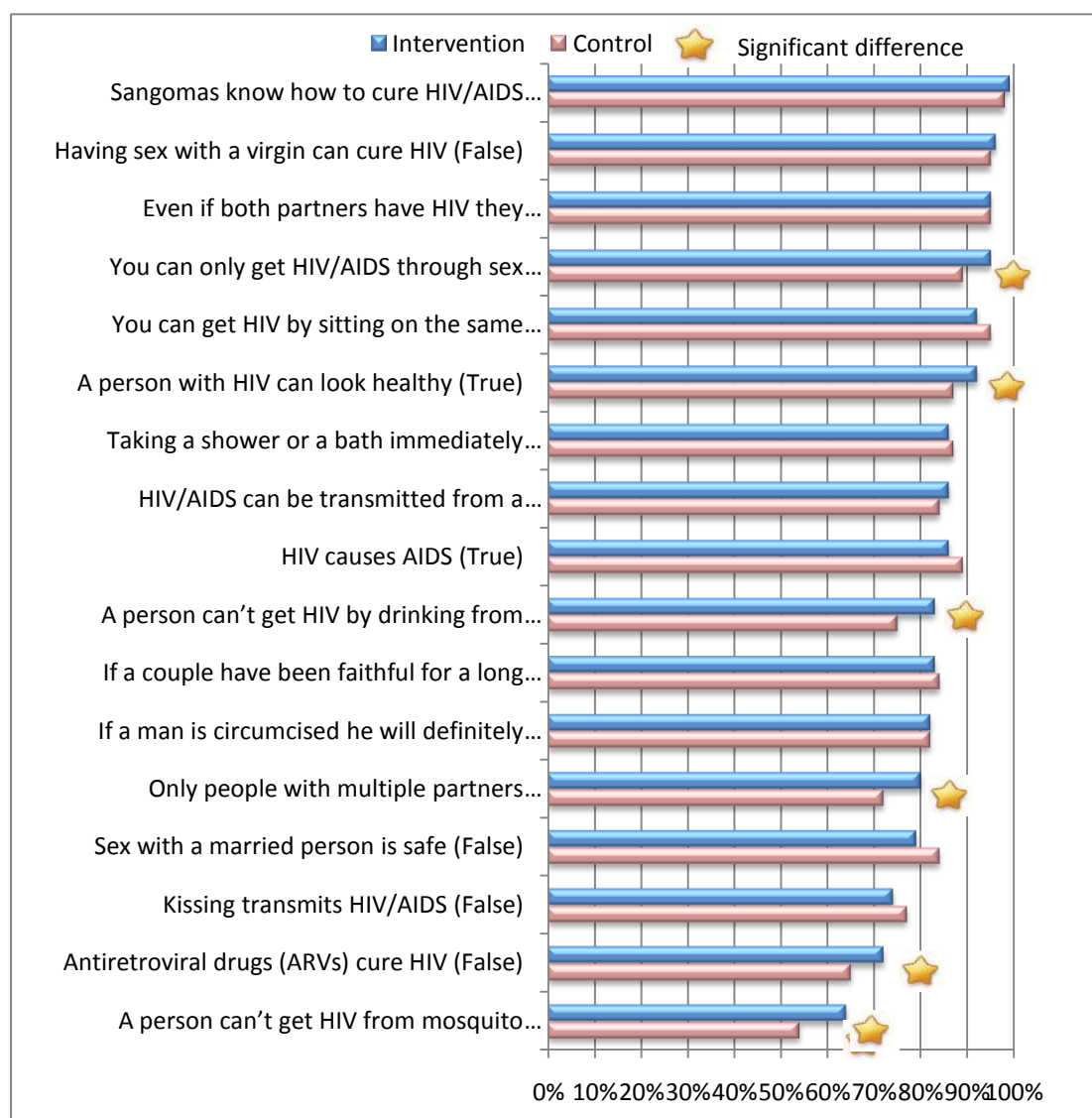


Figure 2. Percentage of learners who correctly answered each HIV knowledge item for intervention and control groups

Increased confidence and self-esteem

One of the major outcomes of the HIV education programme was an improvement in learners' confidence and self-esteem. Principals and teachers agreed that many learners are more outspoken and are able to ask questions more boldly. They are less withdrawn and have confidence to speak in front of the class and express themselves more freely. One teacher noted that *"there is boosted morale"* at the school.

OVC focus groups also recognised an improvement in self-esteem. One boy who had lost confidence when his father died shared that May'khethele had helped him to believe in himself again: *"When he died, I could not believe in myself and there was nobody to praise me when*

*I have done well. May'khethele told me that I will still be a man one day even if my dad is not around.*⁴⁴

*"I once had low self-esteem, when I pass a group of people and I hear them laughing I would think that they were laughing at me. Now I do not care what the next person says or think about me."*⁴⁵

Focus group respondents felt that a strength of the programme is that it teaches self-awareness and that they are better able to recognise their emotions:

*"It is important to know who you are and what you want in life."*⁴⁶

Significantly⁴⁷ more learners in the intervention schools described themselves as "...as happy as other learners my age" than in control schools (Figure 3), reflecting an increase in self-esteem, and echoing the qualitative findings.

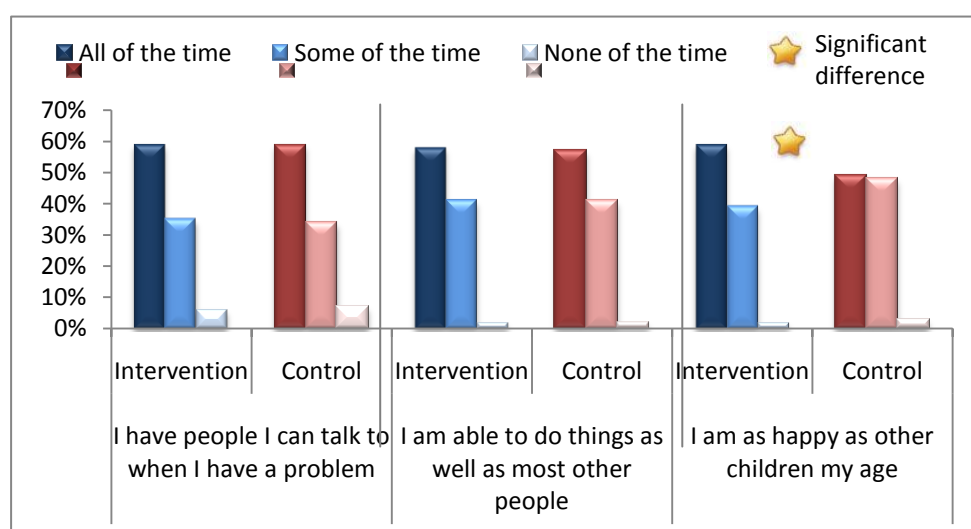


Figure 3. Comparison of intervention and control groups on emotional wellbeing items

Enhancing positive social behaviours

Another programme outcome was an increase in learners' positive social behaviour. Focus groups commented that the programme had taught them concepts such as sharing, forgiveness and empathy and that they are applying these in their lives. Teachers at some schools added that since the programme learners have exhibited improved discipline and there is less fighting at school.

⁴⁴ OVC focus group 1

⁴⁵ OVC focus group 1

⁴⁶ OVC focus group 1

⁴⁷ Chi-square = 7.700 p<0.05

*"I have learnt to share with those that have less than me."*⁴⁸

*"They taught me the importance of forgiving. Before May'khethele, I used to keep grudges. There were many people that I did not talk to. I talk to all of them now..."*⁴⁹

*"They taught me to respect other people and to say things that will make the other person happy."*⁵⁰

*"I was short-tempered. Always fighting with people and get suspended from school. I now can be patient with other people."*⁵¹

Schools and learners have gained greater awareness of the needs of others and have initiated social support projects for those in need.

*"We see what is happening in the community and now we are more involved."*⁵²

Learners themselves have become more open to sharing and helping others.

*"Because of what I learnt from May'khethele I was able to help a friend. His family was struggling and didn't have any decent clothes. I told my family and since then we help them with whatever we can clothes, food, etc."*⁵³

*"I had a friend who also boards at the school. In January she couldn't come to school because she didn't have uniform. I spoke to my mother who gave me permission to give her my other uniform because I have two sets. If I hadn't learnt about sharing at May'khethele I don't think I would have even cared about my friend."*⁵⁴

5.2.4 HIV testing as a prevention intervention

The May'khethele programme provides school-based or highly accessible non-medical sites for HIV testing for learners, as well as CCP offering home testing where appropriate. Lifeline also offers an immediate CD4 cell count should a learner test positive. Qualifying learners are referred to the nearest clinic for ART treatment, and learners are followed up both in terms of their health and their psychological wellbeing. Learners who test HIV+ are included as vulnerable, and enrolled for intensive support under the OVC programme.

⁴⁸ OVC focus group 1

⁴⁹ OVC focus group 4

⁵⁰ OVC focus group 5

⁵¹ OVC focus group 5

⁵² Principal interview 4

⁵³ OVC focus group 4

⁵⁴ OVC focus group 3

May'khethele staff and OVC focus groups considered an increase in testing to be a major outcome of the programme at most of the intervention schools.

“If they had not spoken at length about the importance of HIV testing, I will not know my status. Before they came, I used to hear other people talking about testing. Even on radio they talk about it but I was just not interested.”⁵⁵

Respondents regarded the many learners who have taken an HIV test as a direct result of the programme.

“They advised and encouraged us to go for HIV tests and I went to get tested in 2010.”⁵⁶
“My family and I now get tested every 3 months.”⁵⁷

The majority of learners in both the control and intervention groups reported that they had been tested within the past year (Figure 4), without significant difference between the control group and the May'khethele schools.

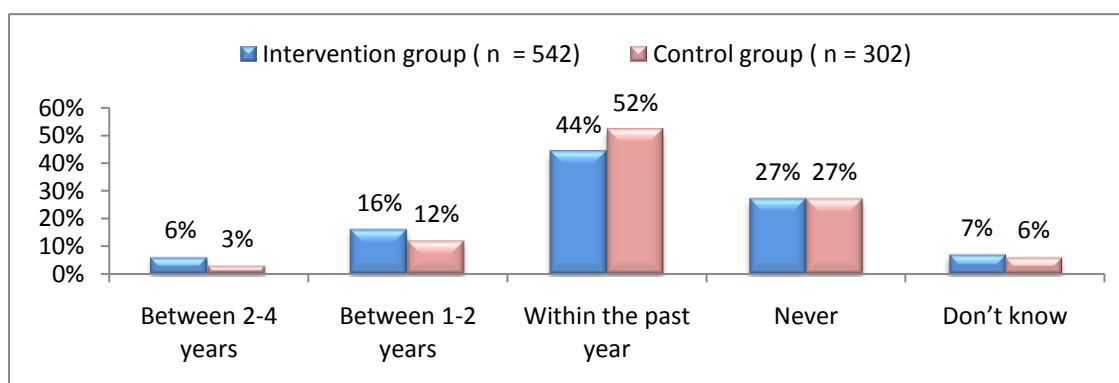


Figure 4. Time since last HIV test

Testing rates varied considerably between the three May'khethele partners (Figure 5). Testing rates were highest at Lifeline schools, where testing is a core service provided by the organisation, with 96% of learners having had an HIV test. Testing rates were lower at CCP schools (64% of learners had been tested) where learners were referred to Lifeline for testing, until 2010 when CCP began to provide HCT in schools and in OVC homes. Testing was lowest at YFC schools (58% of learners had been tested) where learners were referred to Lifeline, despite provision of transport, and Lifeline and YFC collaborating on testing campaigns designed specifically for learners at these schools.

⁵⁵ OVC focus group 1

⁵⁶ OVC focus group 3

⁵⁷ OVC focus group 2

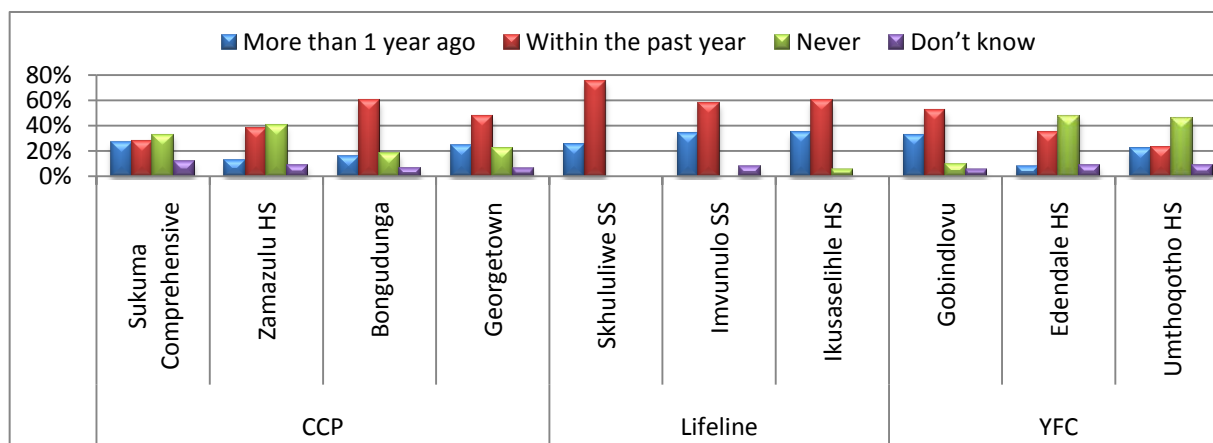


Figure 5. Time since last HIV test, broken down by partner organisation

5.2.5 Prevention and attitudes to risk behaviour

Following their May'khethele experience, more learners are practicing safer sex or abstaining from sex. Principals and teachers at 3 of the 5 interviewed intervention schools reported a decrease in the pregnancy rate, especially for Grades 8 to 10.

*"Before May'khethele I was always giving in to peer pressure, doing drugs and going around with boys. I realise that if I'd continued the way I was going, I'd have ended up pregnant or even worse – HIV positive."*⁵⁸

*"Because of the May'khethele teachings, I stopped being a player, fooling around with girls because I learnt that this behaviour will lead me to getting HIV."*⁵⁹

*"AIDS is dangerous and there is no cure for it, you must know ways to protect yourself from it."*⁶⁰

The great majority of learners give correct and appropriate answers to survey question on HIV prevention. Equal percentages (78%) of learners at the intervention and control schools believe that abstinence is the best method to prevent HIV (Figure 6 and 7). Significantly⁶¹ more learners at the intervention schools stated their intention to abstain up until marriage than at the control schools. Whilst OVC focus groups recognised the importance of abstinence, there was debate about whether this is realistic. Most participants felt that abstaining until the age of 18 years was more realistic than until marriage.

*"I prefer a condom even though it is not 100%. It is unlikely that one will abstain, you can abstain if you are younger, for example 13 years, but once you are 18 years it will be difficult to abstain."*⁶²

⁵⁸ OVC focus group 2

⁵⁹ OVC focus group 2

⁶⁰ OVC focus group 1

⁶¹ Chi-square = 6.291 p<0.05; comparison of 3 control schools

⁶² OVC focus group 1

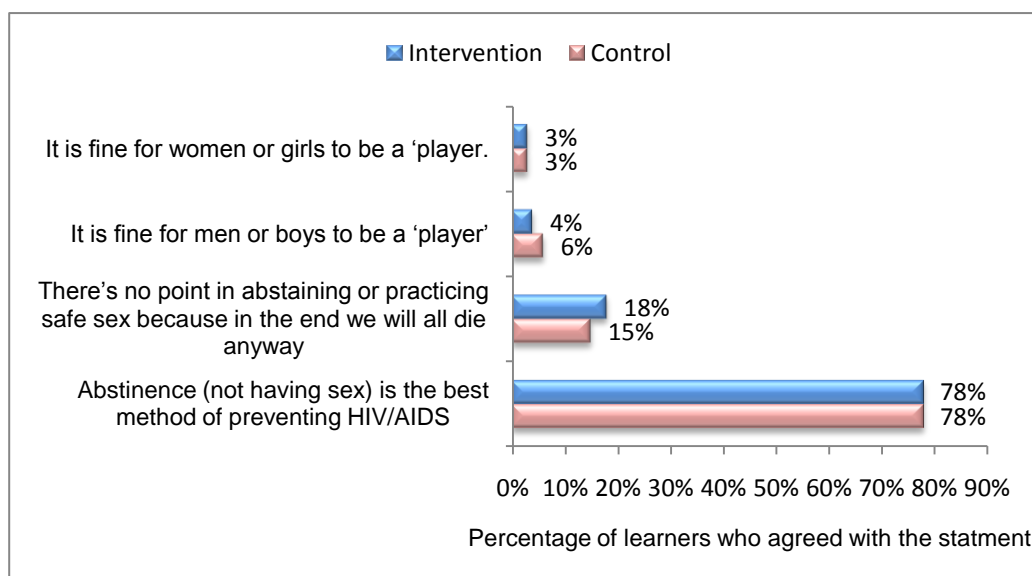


Figure 6. Attitudes to HIV prevention A ⁶³

The vast majority of learners believe that it is not acceptable for males or females to have multiple concurrent partners (be a player). OVC focus groups reported that since the programme they have greatly reduced the risk in their own sexual behaviour. They are using condoms and are no longer 'sleeping around'. 78% and 75% of learners from the intervention and control groups respectively indicated that they would use a condom every time they have sex. Peer leaders at the schools are less convinced that other learners are now using condoms, but observed that *"some are trying to be faithful to their partners."* ⁶⁴

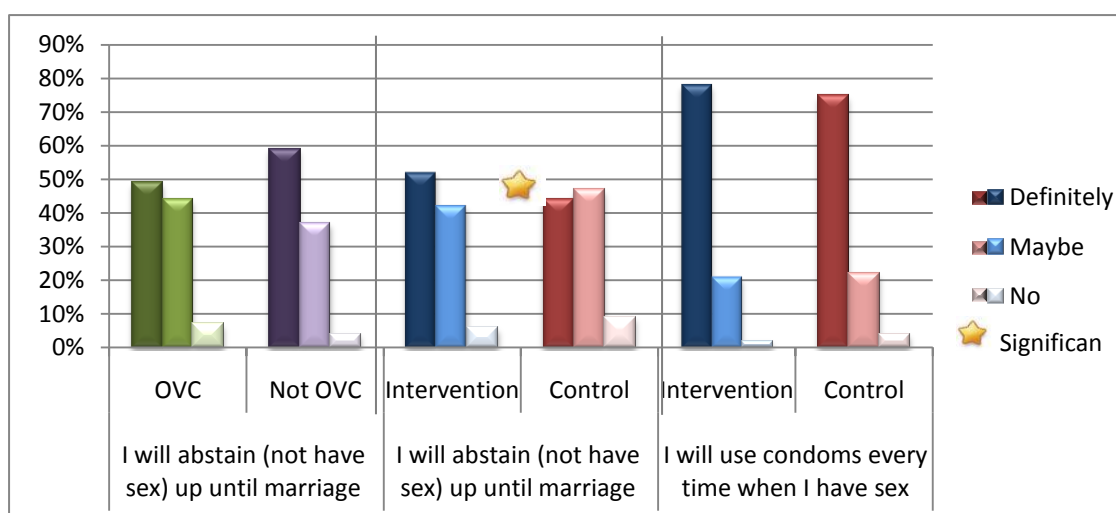


Figure 7. Attitudes to HIV prevention B ⁶⁵

⁶³ Note that OVC in all graphs refers to learners enrolled in the May'khethele household level support programme, and non-OVC refers to all other learners at intervention schools

⁶⁴ Peer leader group interview

⁶⁵ Note that OVC in all graphs refers to learners enrolled in the May'khethele household level support programme, and non-OVC refers to all other learners at intervention schools

5.2.6 Stigma associated with HIV and AIDS

Focus groups and interviews suggested a noticeable decrease in stigma at some schools, although it remains a challenge in others. While some teachers felt that there is still a long way to go to combat HIV stigma, teachers at other schools noticed that learners talk about HIV more and find it easier to open up.

“I know now that I should not discriminate against HIV positive people because they are still the same people as they were before they found out that they are HIV positive.”⁶⁶

“There is not as much denialism. They acknowledge HIV exists.”⁶⁷

“The learners we get from the programme are open-minded. When we talk to them about HIV they do not see it as a rude subject. They have the knowledge.”⁶⁸

Predictably, stigma attitudes depend on the level of social closeness (Figure 8). 89% of learners from intervention schools, significantly⁶⁹ more than those in control schools, stated that they would support their HIV-positive peers. This would seem to reflect a clear outcome of May'khethle's focus on self-esteem and interpersonal relationships.

“I learnt not discriminate but to take care of my loved ones if they are HIV positive.”⁷⁰

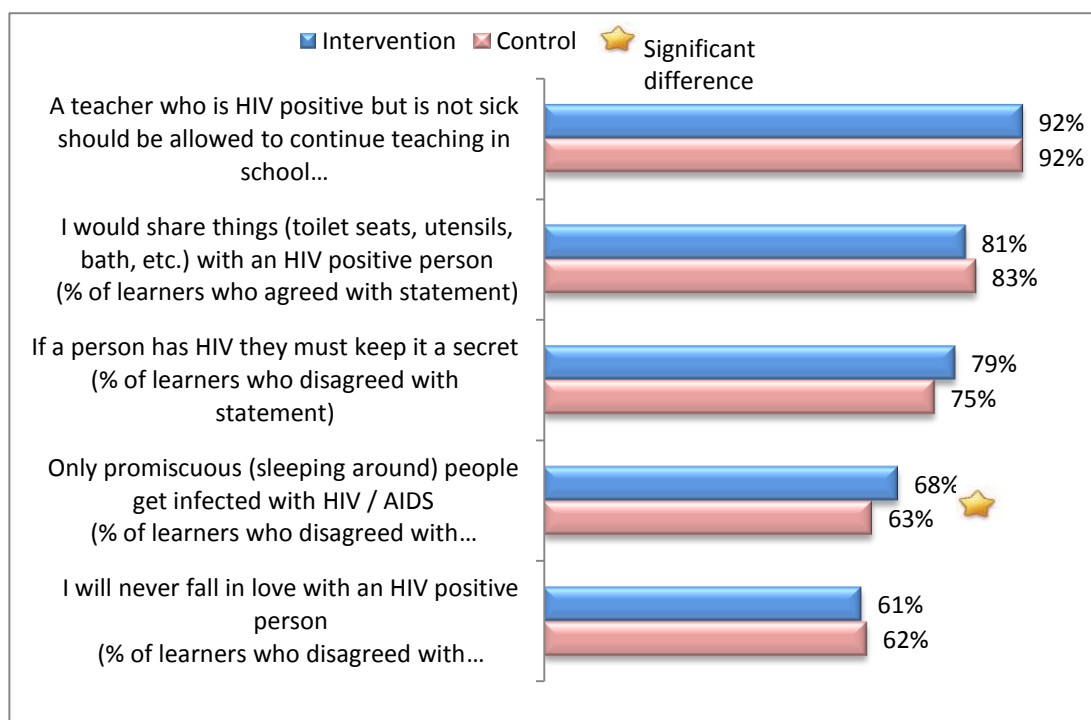


Figure 8. Scores on stigma related items for intervention and control groups

⁶⁶ OVC focus group 4

⁶⁷ Principal interview 4

⁶⁸ NGO interview

⁶⁹ Chi-square = 8.003 p<0.05

⁷⁰ OVC focus group 3

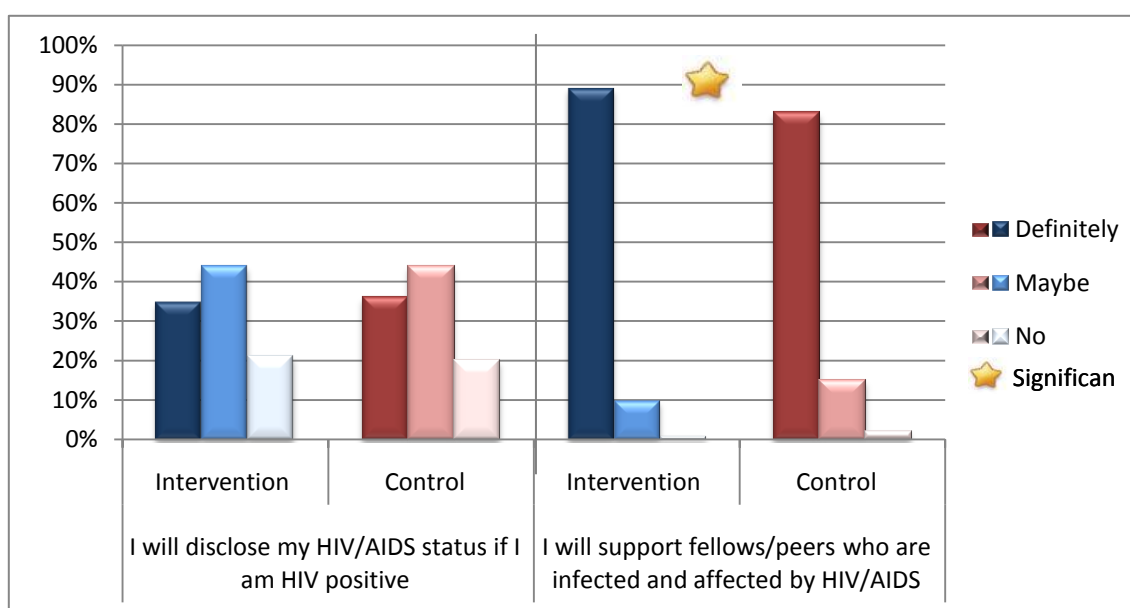


Figure 9. Responses to stigma items on supporting HIV positive peers and disclosing HIV positive status for intervention and control groups

Impersonal relationships and sharing of objects are held with comfort by over 80% of respondents. The thought of communicating and disclosure are accepted by 79% of the intervention group. A personal relationship with a person living with HIV, however, is considered too close by 39% of learners in the intervention group, demonstrating an undercurrent of fear and difference associated with HIV.

The link between ‘social proximity’ and stigma was echoed in the qualitative data. Learners are comfortable to talk about HIV. They know not to discriminate against people who are HIV positive and have become more accepting of people with HIV⁷¹. However, when it comes to openly disclosing their own status, teachers and caregivers noted that the majority of learners are not willing to do so for fear of discrimination (Figure 9).

5.2.7 Improved communication about HIV

Previously a taboo subject in families, learners feel more informed and confident to speak about HIV in their families.

“I’m now able to talk to my parents about HIV and STIs.”⁷²

“My mother used to say I’m too young to be talking about sex. Because of May’khethele, I’m now comfortable to go talk to her about everything and go to her for advice.”⁷³

⁷¹ Teacher group interview 6

⁷² OVC focus group 2

⁷³ OVC focus group 2

*"Parents are allowing learners to go for testing, because the learners understand about HIV and transfer this knowledge to parents. Because of the programme there are no misconceptions and they know exactly what HIV is about and the consequences."*⁷⁴

"Talking about sex and HIV was always taboo but my children say 'Gogo, we learn about these things at the L.O. class and the May'khethale programme.'" ⁷⁵

*"In the past, we couldn't talk about HIV. Now I'm comfortable to talk to my children about HIV. This removes the stigma of HIV. It is now like any other illness, like diabetes."*⁷⁶

5.2.8 Identifying and resolving child abuse

A major outcome observed was an increase in disclosure of domestic violence and sexual abuse. This is attributed to learners being more aware of their rights and also having the opportunity, often for the first time in their lives, to disclose to a trusted adult.

*"Learners know that if a person touches you in an improper way they must report it. They are aware of their rights because before they weren't aware that this was wrong."*⁷⁷

Learners are not only reporting abuse to the May'khethale facilitator but have also started to disclose to teachers. This may reflect a deepening in the relationship between teachers and learners, and greater trust of adults in positions of support. Teachers also spoke about how they themselves have learned to be more aware of signs of abuse and appropriate action to help learners who are affected by abuse.

*"I even went to court as a witness for child abuse, I was her teacher and she disclosed to me."*⁷⁸

*"There was domestic violence and this learner became reserved and wouldn't participate. She was able to speak out and through the programme we relocated her... The father came to the school to threaten us but the school stood up for her. We are willing to help the learners but May'khethale gives us the advice and skills."*⁷⁹

5.2.9 HIV attitudes and HIV education outcomes among enrolled OVC

A positive attitude change has been seen across learners in the intervention schools, and particularly among enrolled OVC. Peer leaders at the schools explained that many OVC are depressed and even suicidal, but that the programme, "gives confidence so that you know what

⁷⁴ Teacher interview 1

⁷⁵ OVC caregiver focus group 1

⁷⁶ OVC caregiver focus group 1

⁷⁷ Principal interview 4

⁷⁸ Teacher group interview 4

⁷⁹ Teacher interview 5

you want in life and so that you don't lose hope." ⁸⁰ Other NGO's which work with the programme also observed less hopelessness amongst OVC and attributed this to the psychosocial support provided by the programme.

"The programme provides counselling and it helps the learners to value themselves and to accept their situation – that they [learners who are HIV positive] can live after HIV. It helps them think of the future and that they can live a positive life." ⁸¹

"They have hope because they have someone to talk to; they see someone is interested in their life and willing to help." ⁸²

The programme has enabled OVCs to speak out about their problems and to ask for help. OVC focus groups describe how before the programme they had been unable to talk about their problems through fear, a lack of opportunity, or not seeing the value in talking to someone.

"I couldn't talk about the things that were troubling me, but now I can easily talk to the May'khethele people." ⁸³

"They make it easy for you to talk about things that are worrying you. I like them because they are loving and they help us forget our problems." ⁸⁴

"Now I am no longer afraid to talk to them about anything." ⁸⁵

While enrolled OVC and non-OVC answered similarly for the majority of questions around HIV and sexuality in the survey, there were a few notable exceptions. Enrolled OVC have less cautious, and perhaps more worldly-wise, expectations of abstinence (Figure 7). Significantly more OVCs (37%), than non-OVCs (27%), in the intervention group believe that only promiscuous people become infected with HIV. Although low, significantly more enrolled OVCs (6%) than non-OVCs (2%) believe it is acceptable for males to be promiscuous.

⁸⁰ Peer leader interview

⁸¹ NGO interview 5

⁸² Teacher interview 5

⁸³ OVC focus group 5

⁸⁴ OVC focus group 1

⁸⁵ OVC focus group 5

5.3 EVALUATION QUESTION 3: COMMUNITY AND HOUSEHOLD SERVICES

How effective were the services provided to OVC households in terms of improving care to OVCs?

Major conclusions

The comprehensive, integrated, child-centred, holistic, household level nature of OVC support has been effective and is recommended as good practice. The model demonstrates the value of the real needs of OVCs being addressed by a single caring adult, whether these relate to food, housing, protection, and psychosocial support and information, and when support to physical needs are strongly complemented by support to emotional needs. This is an essential design element for programmes hoping to enhance the rights and wellbeing of children and youth. Given the lack of hope and general family depression among people living in poverty, even greater availability of support groups, home visits, and peer support would be appropriate.

Innovative approaches to sustainable livelihood support have been a valued part of the programme, particularly in the form of food gardens. Training and projects in local economic development are beyond the scope of the CINDI network's role, but active partnerships with organisations that focus on economic self-reliance and sustainable financial security would benefit OVC.

Continuity and follow-up of OVC needs and services are a key success factor.

Encouraging community buy-in and participation is an ongoing area of effort as OVCs continue to be excluded and isolated. May'khethele has focused on building community spirit, and should continue to work to achieve a sense of community responsibility for OVCs. Involvement of community leaders and partnerships with churches and religious leaders as powerful sources of influence is recommended by respondents.

5.3.1 Psychological care

Research shows that there is a dire need for psychosocial support for OVCs⁸⁶. Young people who are orphaned or made vulnerable by illness, poverty, homelessness or abuse invariably struggle with the trauma of these experiences. In addition, they are likely to encounter stigmatisation and rejection, aggravating their emotional distress. They are less likely to have sufficient adult supervision, support or containment. They may respond with inappropriate and unsafe behaviour, less maturity of judgement and low self-esteem, and are therefore particularly vulnerable to HIV infection.

The May'khethele programme provides psychosocial support to OVCs in the school setting, with additional support in the home environment, as well as referral for professional counselling where needed.

⁸⁶ PEPFAR, 2006

“The programme is doing a good job because it doesn’t concentrate only on HIV. It also looks at all of the child’s needs and then helps them.”⁸⁷

Caregivers also receive support that helps them to feel cared for and less isolated. Some caregivers explained that the programme helped to restore their dignity and others felt more confident to care for their children. By empowering caregivers and providing support the programme contributes to helping them better care for OVCs.

5.3.2 Enabling documents

Birth certificates, death certificates and identity documents are essential for access to virtually any service, and to normal engagement in society: *“Without these documents you can’t have a normal life.”⁸⁸* One of the most compelling motivations for families to obtain documents is that access to social grants requires children’s birth certificates and, if relevant, parents’ death certificates.

May’khethele has offered support, advice and information to caregivers, improving access to birth certificates for learners. 95% of learners in the intervention group have a birth certificate. This is significantly⁸⁹ more than the 90% of learners in the comparable control group.

May’khethele’s partnership with the Department of Home Affairs (DHA) has helped to improve OVCs’ access to enabling documents, helping to identify learners and schools where the need is greatest. May’khethele provides the department with a link into communities by generating a list of schools which need DHA services, and arranging DHA visits to schools.

5.3.3 Home- based HIV testing

The benefits of testing are recognised by OVCs:

“Knowing your status helps you to take ARVs early; even here at school there are learners who take ARVs. I know because my uncle was taking the same pills.”⁹⁰

“If you discover that you are HIV positive you will be able to protect another person from being infected by you.”⁹¹

Although HIV testing is offered at some of the intervention schools and at partner organisations’ premises, often the most vulnerable families find it difficult to go out to access testing services. It is much easier to accept a caregiver into their homes. May’khethele

⁸⁷ NGO interview

⁸⁸ DHA official interview

⁸⁹ Fisher’s test = 6.188 p<0.05

⁹⁰ OVC focus group 1

⁹¹ OVC focus group 1

therefore includes an invitation for home-based testing as part of home visits which has been led by CCP.

“We enjoy their home visit. I wish they would visit again. They came to do VCT after my mother had passed away. They explained nicely why this was necessary.”⁹²

“They helped with the testing of my late aunt’s children that I’m taking care of. Knowing their status put my mind at ease.”⁹³

May’khethele’s testing service is provided in close partnership with the Department of Health (DOH). The department provides testing supplies and the programme increases learner access to HCT.

“DOH can’t infiltrate the whole community. DOH don’t have the resources to do what they [May’Khethele] are doing.”⁹⁴

5.3.4 HIV management support

Learners diagnosed as HIV-positive are enrolled into the May’khethele OVC programme. Caregivers also learn how to better care for HIV-positive learners, as well as themselves if they are HIV positive.

“The programme goes beyond the child – it goes to the family and teaches caregivers about HIV. They learn that it is manageable.”⁹⁵

“They taught me how to care for HIV-positive person. One is able to ask questions and be assisted.”⁹⁶

“Because of the training I’m now able to see if a child is sick and know what to do.”⁹⁷

“I’ve done home-based care training and I’m now able to share my knowledge with my children.”⁹⁸

5.3.5 Educational support

Lack of school fees and school uniforms are major obstacles to school attendance. The May’khethele programme has improved OVCs’ access to both. May’khethele arranges direct assistance to some OVCs for school fees and negotiates with schools on their behalf if they cannot pay school fees. May’khethele also ensures that OVC learners have uniforms, with

⁹² OVC focus group 3

⁹³ Caregiver focus group 2

⁹⁴ DOH officials’ group interview

⁹⁵ Staff interview 1

⁹⁶ OVC caregiver home visit 1

⁹⁷ OVC caregiver focus group 2

⁹⁸ OVC caregiver focus group 1

significantly⁹⁹ more learners in the intervention group having uniforms than in the control group (Figure 10). Although significantly fewer OVCs have a uniform than non-OVCs, the 95% who do have uniforms remain higher than the 89% of learners in control schools.

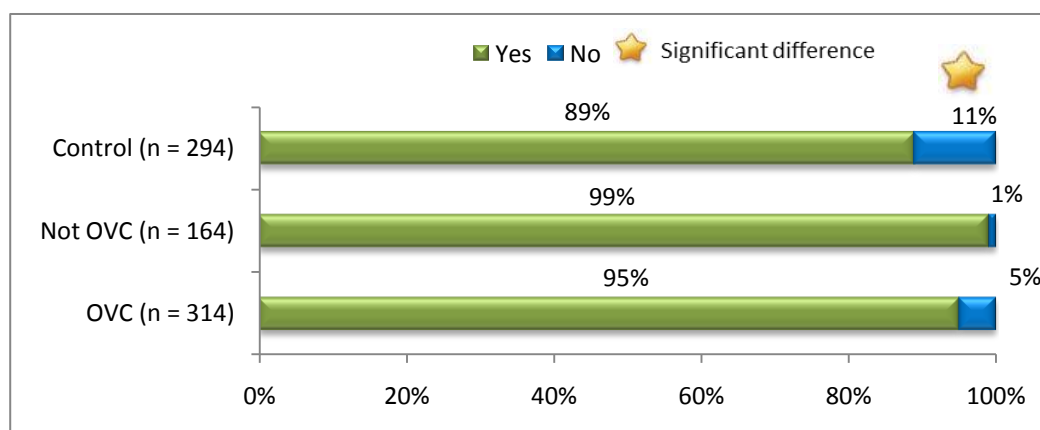


Figure 10. Child has a school uniform to wear to school

5.3.6 Household economic strengthening

The household economic strengthening element of the May'khethale programme concentrates on establishing food gardens in the households of enrolled OVC as well as helping caregivers to access social grants.

The programme conducts OVC nutritional assessments. Learners in need of immediate food support are referred to appropriate programmes. For longer term food security, the programme encourages and supports the establishment of food gardens in OVC households, providing both enhanced nutrition and a source of income. Although food gardens have taken a long time to take hold in people's minds, successes have started to be seen.

*"The food gardens were not working because there was no hope. They have started to work and this indicates the emotional health of the family."*¹⁰⁰

For the majority of caregivers participating in focus groups, the food gardens were a key programme element.

*"Selling the vegetables gives us income to provide other necessities for our families without depending solely on the grants."*¹⁰¹

*"We never have to spend money on vegetables, having the gardens helps keep the hunger at bay."*¹⁰²

*"We are able to sell our vegetables and buy bread."*¹⁰³

⁹⁹ Chi-square = 19.402; p<0.05

¹⁰⁰ Staff interview 2

¹⁰¹ OVC caregiver focus group 1

¹⁰² OVC caregiver home visit 4

5.3.7 Continuity and follow up

May'khethele's systems of household centred, holistic support, and careful follow-up on OVCs' access to services was identified as a key factor for programme success.

*"May'khethele follow up on the child, they don't just leave them."*¹⁰⁴

*"May'khethele visit and check us regularly."*¹⁰⁵

5.3.8 Community-based presence

The programme is well-positioned to access the community. It can target areas where there is the most need. By *"taking services to the area"*¹⁰⁶, May'khethele reaches the most vulnerable.

*"They are a useful resource because they are community based so they know what is out there."*¹⁰⁷

May'khethele has experienced a lack of community buy-in and has had to work at involving communities in the programme and bringing back a community spirit. Although there have been challenges to community participation in the programme, May'khethele has assisted with community development in a number of ways. Through working with local churches it has encouraged church members to be more community-minded and challenged them to uplift the community¹⁰⁸. By sourcing field staff from local communities, mutual understanding and respect between the programme and its client base is enhanced.

5.4 ADDITIONAL EVALUATION QUESTION: PROGRAMME MANAGEMENT AND INSTITUTIONAL ARRANGEMENTS

What are the lessons and good practices learned from the management and organisational approach taken by the May'khethele programme?

Major conclusions

The consortium approach under the CINDI umbrella has offered several key advantages. The programme has been able to provide a range of services in a responsive, flexible and yet

¹⁰³ OVC caregiver focus group 1

¹⁰⁴ NGO interview 1

¹⁰⁵ OVC caregiver home visit 3

¹⁰⁶ NGO interview 1

¹⁰⁷ NGO interview 3

¹⁰⁸ NGO interview 5

comprehensive manner. A key success of the programme has been strong project management and the establishment of effective systems and processes, particularly processes for regular reflection and action learning. With facilitation by CINDI leadership, the team has been able to design approaches and adjust them with experience, providing a continuously improving model approach.

While the consortium approach offers the advantages of a range of capabilities from different partners and opportunities for exchange and synergy, variation between the approaches taken by partners sometimes requires compromises and careful management.

As this phase of the programme draws to a close, managers intend to share the May'khethele joint partnership model with the OVC and education sectors as an example of good practice. Funds are also being raised for CINDI itself to continue to work within the same paradigm. It is recommended that the key success factors be carefully taken into account when working towards taking the model to scale. These include firstly, the enthusiastic investment of young, well-trained, well-mentored adults, who provide the entire school with lay counseling alongside holistic sexuality, lifeskills and HIV education. Secondly, the model's success depends on being able to identify OVC and provide family-centred community care, which is regular, personalised and prepared to take action to resolve the range of constraints to OVC realising their rights.

5.4.1 Reflective, learning-oriented joint venture

No single organisation or government department is able to provide services to OVCs that cover all aspects of their needs. Coordination within and between community organisations, government departments and different levels of government, is paramount in achieving comprehensive and holistic service provision.

The consortium model employed by the May'khethele programme has been highly successful. It enables both reach and depth in servicing OVCs; flexibility and adaptability; and capitalises on the strengths of each partner organisation providing for a range of skills and professional capacity¹⁰⁹.

A key success of the model has been the commitment to strong project management and the establishment of effective operating systems and processes, some of which included:

- effective communication and feedback mechanisms (in part through a live database)
- streamlined coordination
- genuine critical reflection and a culture of learning which was incorporated back into the programme
- monitoring and evaluation systems.

¹⁰⁹ Staff interviews

Another essential element contributing to programme success has been ongoing capacity building and support at different levels. CINDI and partner organisations received valuable technical training from PACT SA, and partner organisations received further significant training from CINDI. When second level support was needed by partner organisations, such as financial management and monitoring and evaluation, this was also provided by CINDI.

The joint partnership model, with its key systems and management practices, provides a good practice model for the sector. The May'khethale programme intends to share this model with the sector. such that the valuable lessons learnt can contribute towards sustained, effective OVCs support.

5.4.2 Partnerships and networking

Beyond its core group of partners, May'khethale links with other relevant services to enable comprehensive service provision. Shared standards and professional culture are established through networking and partnership building, demonstration, benchmarking and communication.

Government

Many of the May'khethale programme staff commented on the challenges in building relationships with government departments, describing it as a slow process which requires much time and effort. May'khethale has been relatively successful at strengthening partnerships with government. The programme works predominantly with the four government Departments of Education; Health; Social Development; and Home Affairs. As a result, May'khethale's beneficiaries receive services more comprehensively and expediently. Government departments gain access to hard-to-reach households and receive information on prioritising the most vulnerable.

“DHA is happy to be in partnership with them. They assist us a lot and the mobile unit is there to work closely with NGOs.”¹¹⁰

May'khethale's involvement has greatly increased access to HCT for learners, and has included the critical role of follow-up and support needed to safely offer HCT services to school youth.

“They [May'khethale] contribute a significant number to the HCT campaign. Whenever we have events they assist us.”¹¹¹

¹¹⁰ DHA official interview

¹¹¹ DOH officials group interview

Linking with NGOs

Effective referral system: May'khethele networks, refers clients and follows up with NGOs to enable access by their beneficiaries to specific services and professional skills.

Working together to utilise each other's strengths: May'khethele partners with other NGOs to offer more effective services and to minimise duplication. For example, if legal intervention is needed to remove the child from an unsafe home, May'khethele asks Pietermaritzburg Child Welfare to assist. May'khethele reciprocates by identifying places of safety for children and helping them to access enabling documents.

Capacitating other NGOs: May'khethele has helped to capacitate other NGOs that work with learners in the community. For example, through May'khethele a shelter NGO receives resources, training, and assistance with funding applications¹¹². In turn, the May'khethele programme brings learners in need to this place of safety so that they are cared for until they can be permanently placed.

¹¹² NGO interview 2

6 CONCLUSION

The programme is effectively designed to provide holistic education, care and support at school, home and community levels. This has provided several principles of good practice, having demonstrated how school-wide education, life-skills facilitation and counselling can be effectively integrated with needs-based household support. The streamlined model demonstrates the flexibility possible to provide services as varied as HCT, documentation and life-skills around sexuality and HIV prevention, while also ensuring that a consistent, rigorously designed curriculum can be developed and rolled out across a large number of participating schools.

While fine programme refinements might benefit the model, the May'khethele programme has largely been a success. Although the programme is coming to an end at the conclusion of the grant period of the PEPFAR funding, the relevance of the programme in terms of lasting solutions to the OVC crisis is assured in the programme's sustainability plans. The model will be shared with the OVC and education sectors as an example of best practice in order to assist with developing a scaled, sustainable programme model for the sector.

The design of systems that effectively address what amounts to a 20-year emergency is a major achievement. An entire generation of traumatised, damaged and under-parented children require society as a whole to care for them. Holding this generation through to adulthood as self-reliant, effectively participating and well-adjusted members of society is a daunting challenge facing all those working in the children's sector, and indeed, all members of a responsible and ethical society.

7 SUMMARY OF RECOMMENDATIONS AND GOOD PRACTICE

1. The comprehensive, integrated, child-centred, holistic, household level approach of the OVC element of the programme is a key success factor. Despite care, OVCs remain more vulnerable than non-OVC. The model is effective when the real needs of OVCs are addressed by a single caring adult, whether these relate to food, housing, protection and psychosocial support and information, and when physical needs are strongly complemented by support to emotional needs.
2. An especially powerful programme element, which is recommended across school-based OVC programmes, is the provision of lay counsellor-facilitators who are approachable, knowledgeable, independent young adults. This person offers support, access to problem solving and focused attention, thereby enhancing self-value and self-esteem among learners. While professional psychologists are clearly essential in cases of severe trauma or abuse, readily available facilitators fulfil a valuable role for a larger number of learners. Both professional and non-professional levels of psychological support are recommended.
3. The school-based HIV education model used, which combines personal upliftment with technical information, has been particularly successful. It builds self-esteem, confidence, social responsibility and emotional maturity, while enhancing HIV knowledge. Facilitation could be further enhanced with facilitator support, supervision, codes of conduct and on-going mentorship and debriefing. A greater range of creative educational approaches could be included, particularly those that exercise learners' expanding confidence in self-expression, participation and critical thinking.
4. Innovative approaches to sustainable household, caregiver and welfare support have been a strong part of the programme, particularly in the form of food gardens, home visits and support groups. With the lack of hope and general family depression among people living in poverty, even greater investment and strategies for confidence-building and emotional support for households would be appropriate. Training and local economic development to households are beyond the scope of CINDI's niche. Active networking with partners who build economic self-reliance and sustainable financial security would benefit OVC.
5. An area where the survey results might have been unexpected is that of HIV testing in CCP and YFC schools, where learners were referred to Lifeline for testing (until 2010 for CCP schools). The quantitative data do not support respondents' impressions that the great majority of learners have tested for HIV. A closer investigation of the obstacles to access and testing uptake, especially when using the referral approach, is advised.

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6. Community buy-in and participation is an on-going area of effort as OVCs continue to be excluded and isolated. May'khethele should continue its valuable work stream towards achieving a sense of community responsibility for OVCs. Continued involvement of community and religious leaders are powerful sources of influence. Without a child-friendly, child-embracing community, organisations cannot single-handedly create a safe and nurturing environment for all children, including those who are vulnerable.
 7. The consortium approach under the CINDI umbrella has offered several key advantages. The programme has been able to provide a range of services in a responsive, flexible and yet comprehensive manner. The model does, however, require a clear awareness and management of the variance between the approaches taken by partners.
 8. The May'khethele programme intends to share this model with the sector as an example of best practice, to encourage its ultimate uptake in schools across the country. It is recommended that the key success factors be carefully taken into account when working towards taking the model to scale. These include firstly, the enthusiastic investment of young, well-trained, well-mentored adults, who provide the entire school with lay counselling alongside holistic sexuality, lifeskills and HIV education. Secondly, the model's success depends on being able to identify OVC and provide family-centred community care, which is regular, personalised and prepared to take action to resolve the range of constraints to OVC realizing their rights.
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